Sheldon Dental Group Office Policies, Procedures, and Patient Authorization

(Initials simply show that you have read and understand, not necessarily that they apply to you or that you agree)

Payments

Sheldon Dental Group accepts payment in the form of cash, personal check, money order, MasterCard, Visa, Discover, and CareCredit. Payment is due at the time of service.

Initials_____

Insurance

If you have insurance, we will be happy to file your claim as a courtesy. However, you will be responsible for your deductible and any coinsurance at time of service. Our computer software estimates what your insurance should cover and estimates what your "out of pocket" portion should be. THIS IS ONLY AN ESTIMATE and it is possible that your insurance may cover less than what is estimated. If this should happen the remaining balance will be your responsibility to pay in a timely manner.

Initials_____

Interest Free Payment Option

We do offer interest free payment options through CareCredit. This company is not affiliated with Sheldon Dental Group and we do not have any control over acceptance in their program. We will assist you in the application process as much as we possibly can. The end result would be an agreement between you and Care Credit.

Initials_____

Full Payment Discount

We do offer a discount for non-preventative services when paid in full the day of service for those individuals without insurance coverage. These discounts are not applicable are not applicable with the use of any offer through CareCredit as they charge Sheldon Dental Group a sizable service fee per transaction that we do not pass down to the patient.

Initials_____

Delinquent Accounts

We will consider an account delinquent when the balance goes unpaid in 60 days without financial arrangements in place or on accounts with financial arrangements that have defaulted on the agreed upon financial arrangement. Accounts in one of the two aforementioned conditions may be turned over to our outside collections agency for handling. Patients who have had their accounts sent to the collections agency will be immediately considered inactive in the dental practice and will only be seen on an emergency basis for 30 days following that inactivation.

Initials_____

After Hours Phone Calls/ Emergency Services

Our Doctors are here for our patients whenever needed. They are willing to take after hours calls for all dental emergencies. Our normal office hours are Monday through Thursday 8am-5pm (lunch from 1pm-2pm), and Friday 8am-3pm. If you have an after hours emergency please call the office main number and the recording will give you the emergency number for each Doctor. If the Doctor comes into the office to see you after hours there may be a $210 fee applied to the visit and this is normally not covered by dental service.

Initials_____

Missed Appointments

It is understood that Sheldon Dental Group may, but is not required to, confirm upcoming patient appointments. Such reminder may be in the form of a postcard, phone call, text email, or any combination of the previous methods. The patient understands this is a courtesy and that they are ultimately responsible for keeping their dental appointments. We request that you give us at least 24 hours if you need to cancel or reschedule an appointment. However, if an appointment is missed without at least 24 hour notice it is understood that Sheldon Dental Group reserves the right to charge a missed appointment fee at our discretion.

Initials_____

Late Arrival For Appointments

We understand busy schedules and that at times things come up out of our control; however if you arrive15 minutes late for your scheduled appointment you **may** be asked to reschedule. This is done out of respect for our other patients who have appointments scheduled. We would ask that you call ahead and let us know if you are running late so that we can try to accommodate you as our schedule permits.

Initials_____

Medical Records Release

We will only share your medical/ personal information when pertinent with other Dental or Medical Professionals with whom we are referring care to if needed. This information will also be used only as needed when submitting insurance claims on your behalf. We will only release x-rays and records once a release form has been signed by the patient.

Initials_____

Consent for Composite (or tooth-colored) Fillings

Our office is dedicated to providing the highest quality dental care to our patients. We do not place amalgam (silver) fillings. Some insurance carriers only provide benefits for amalgam fillings on posterior teeth resulting in additional cost to the patient for composite fillings on those teeth. We will do our best to find out patients insurance benefits, but it is ultimately the patient's responsibility to know their insurance plan coverage. We would be happy to send a pre-authorization to your insurance prior to treatment if there is any question about coverage. It can take a month for us to receive information back from insurance on pre-authorizations.

Initials_____

Authorization to File/ Collect Insurance

I, the patient, hereby give my authorization for the financial office of Sheldon Dental Group to affix my name to any and all claims and/ or documents related to and needed for the processing of insurance/ health benefits on my behalf. With this I am also authorizing the payments of such benefits to be made directly to Sheldon Dental Group.

Initials_____

Authorization For Treatment

I, the patient, hereby give my authorization to the dentist and team members of Sheldon Dental Group to render dental treatment that they judge to be beneficial to my oral and overall health. In giving this authorization it is understood that my dental condition will be explained to me and all options for treatment of said dental condition will be explained thoroughly

It is understood that I have the right to refuse any treatment options presented. However, with refusal of treatment it is also understood that the Doctors at Sheldon Dental Group have the option to refuse future treatment and even dismiss from the practice when such refusal of treatment is seen as detrimental to my future dental health, or compromises the professional ethics of the Dentist or practice.

Initials_____

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND PROCEDURES AND GIVE THE ABOVE AUTHORIZATION FOR TREATMENT TO: SHELDON DENTAL GROUP

I HAVE ALSO BEEN GIVEN THE OPPORTUNITY TO READ AND REVIEW, AND BEEN GIVEN A WRITTEN COPY *IF REQUESTED* BY ME OF THE NOTICE OF PRIVACY PRACTICES FOLLOWED BY SHELDON DENTAL GROUP.

Print Patients Name:_____

Patients Signature:_____Date:_____

If patient is a minor (under 18) or under the care of a caregiver:

Print Responsible Party's Name:_____ Relationship:_____

Responsible Party's Signature:_____ Date:_____

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL A NEW AUTHORIZATION IS COMPLETED AND SIGNED